
CLIENT INTAKE FORM

Name: _____

Address: _____

Telephone (Home): _____ **(Cell):** _____

Email: _____ **SSN:** _____

Age & Birth date: _____ **Marital Status:** _____

Race/Ethnicity: _____ **Number of Children:** _____

Occupation and Employer: _____

Emergency Contact Information:

Name: _____ *Relationship to you?* _____ *Tel Number:* _____

Address: _____

Please describe what brings you to seek therapy at this time: _____

How long have you been having trouble with these concerns? _____

Who is your biggest support at this time? What are you doing to help you cope?

Michelle Lopez PhD Psychology Inc

16959 Bernardo Center Drive Suite 200, San Diego, CA 92128

Email: email@michellelopezphd.com

Phone: 619-800-1566

Have you ever seen a psychologist, psychiatrist, or mental health provider?

Name:

Dates of service:

Treatment for:

Are you currently taking any medications? Prescribed and OTC:

Medication (and dosage):

Date started:

Treatment for:

Prescribed by:

Name and Address of Primary Care Physician:

Name and Address of Psychiatrist:

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Please describe your alcohol, tobacco and/or drug use (including frequency and amount):

How would you describe your physical health?

Please describe any positive health behaviors (i.e. exercise, meditation):

Is there anything else you would like Dr. Lopez to know at this time?

How did you hear about Dr. Lopez's services?

Signature

Date